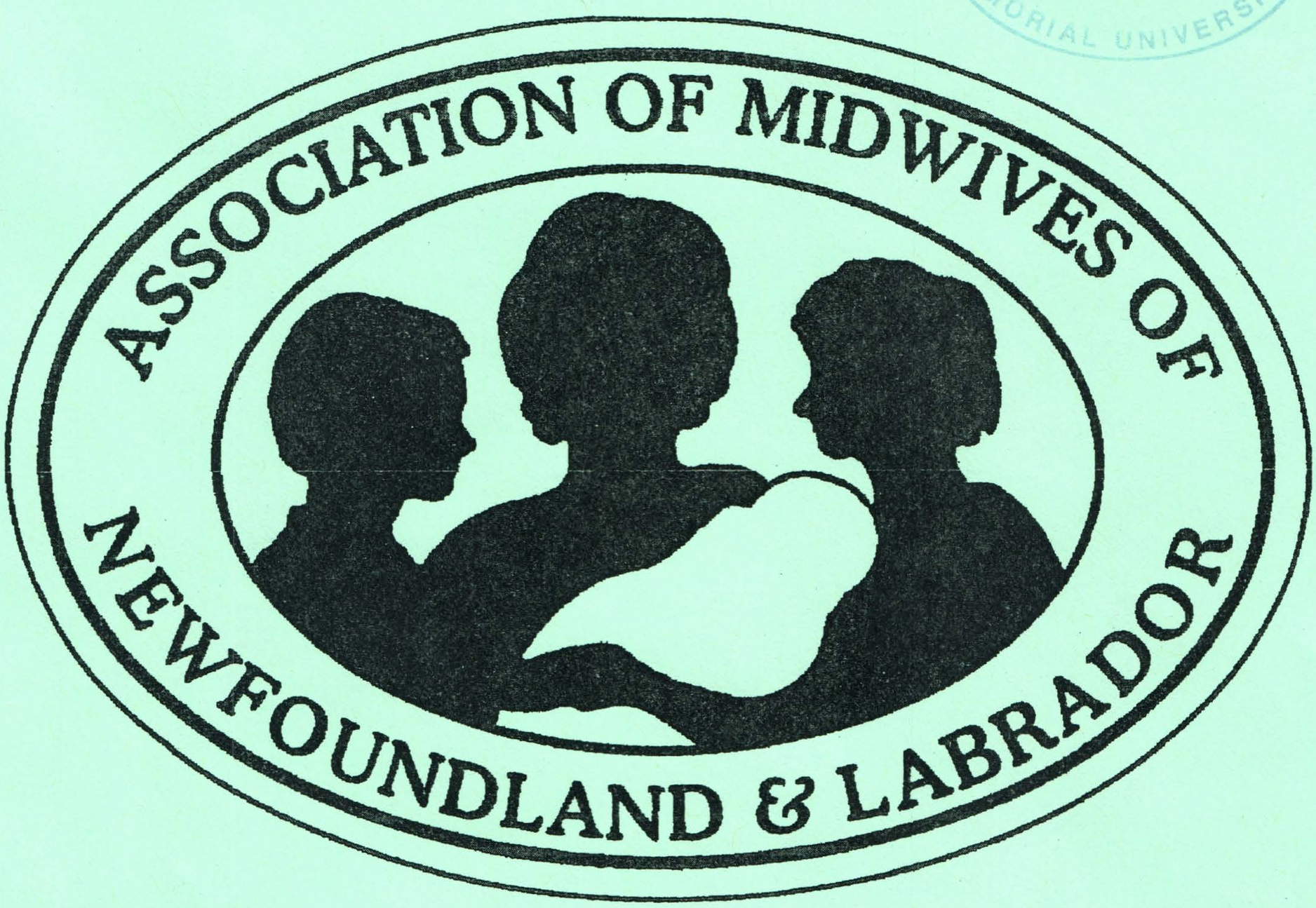
ASSOCIATION of MIDWIVES of NEWFOUNDLAND & LABRADOR



Newsletter No. 32, January 2005

Association of Midwives of Newfoundland and Labrador
(Chapters in Goose Bay and St. John's)
Newsletter 32
January 2005

MISSION STATEMENT

To provide professional information for midwives, and to promote the recognition of the role of midwives, and the need for appropriate legislation so that midwives in Newfoundland and Labrador are publicly funded to legally provide research-based, total midwifery care as a choice for childbearing families in this province. (2001)

This Newsletter contains a summary of the General Meeting held on January 11, 2005.

The annual membership fees for 2005 were due on January 1. There is a membership form at the end of this Newsletter.

This Newsletter is the method by which members are kept informed about midwifery and other maternity matters. Send items and constructive comments to the President for forwarding to the Editor. Thank you for items contributed. Those who submit are responsible for obtaining permission to publish in our Newsletter. The Editor does not accept this responsibility.

Pearl Herbert, Editor.

AMNL Annual General Meeting,
Tuesday, March 15, 2005, 4:00 p.m. (Island time)
The meeting in St. John's will be at Telemedicine, HSC. All sites wishing to be connected need to provide their telephone number to TETRA Telemedicine (1-877-737-0281) prior to the meeting. (For reporting problems during the meeting call 709-737-6654.)

Friends of Midwifery NL
Tuesday, February 15, 2005, 7:00 p.m.
Sobey's Community Room, Old Placentia Road, Mount Pearl

Canadian Association of Midwives Annual Meeting
November 9-11, 2005, Halifax

Executive Committee
President: Karene Tweedie, CNS, 100 Forest Road, St. John's, NL, A1A 1E5
Treasurer: Pamela Browne Secretary: Kay Matthews
Past President: Ann Chaulk Newsletter Editor: Pearl Herbert
Home page: http://www.ucs.mun.ca/~pherbert/ Newsletter in HSLibrary: WQ 160 N457n

Summary of the General Meeting held on January 11, 2005, at 4:00 p.m. (Island time).

There were 9 members present for this general meeting chaired by Karene Tweedie. The development of the video is progressing. Following the meeting those in St. John's were able to view the latest draft. The video was then sent to Goose Bay for viewing. There are no Vision for Midwifery meetings planned, but a lawyer in the city is willing to advise as needed.

There are six doulas who wish to take the NRP course. They require the full programme.

Work on the pamphlet is slowly progressing, but stopped over the Christmas break. It will proceed in February. The choice is white paper, black wording, and a coloured photo.

Karene Tweedie reported that the Office of Nutrition Policy and Promotion of Health Canada has issued two revised infant-feeding recommendations. The first recommendation concerns *Exclusive Breastfeeding Duration*, (2004), [Pub. No. 4824, H44-73/2004E] and that: "Exclusive breastfeeding is recommended for the first six months of life for healthy term infants, as breast milk is the best food for optimal growth. Infants should be introduced to nutrient-rich, solid foods with particular attention to iron at six months with continued breastfeeding for up to two years and beyond". The second recommendation is regarding *Vitamin D Supplementation for Breastfed Infants*, (2004), [Pub. No. 4828, H44-74/2004E]. "It is recommended that all breastfed, healthy term infants in Canada receive a daily vitamin D supplement of 10µg (400 IU). Supplementation should begin at birth and continue until the infant's diet includes at least 10µg (400 IU) per day of vitamin D from other dietary sources or until the breastfed infant reaches one year of age." This information is available on the web site: www.healthcanada.ca/nutrition .

Karene Tweedie has been invited by the ARNNL to become a member of the Advanced Nursing Practice Committee. She has already advised them that midwifery is an autonomous profession and is not part of the discipline of nursing.

A letter has been sent to the new provincial minister of Health and Community Services, and a Christmas card was received from him. Christmas cards were received from some other organizations. Kay Matthews had sent cards to those organizations identified in previous years.

This year Friends of Midwifery NL are arranging for face-to-face meetings, they have started to produce Newsletters, the web site is being constructed, and they are investigating the possibilities of having information stalls in the shopping malls.

The next conference call meeting will be the Annual General Meeting on March 15. As discussed previously, to be passed are: the amended Mission Statement, the Constitution III Objectives, the Bylaw II.5 membership for those who are "underemployed", i.e. employed and receiving minimal wage or facing financial hardship, Bylaw V.A.3 reworded to "the refund of actual expenses supported by receipts, as resources allow".

Nominations are required for President, Secretary, and Treasurer, according to Constitution V.B. The Newsletter editor is appointed according to Constitution V.6.a. Catherine Finn-Hagerman (charliebelle2002@yahoo.ca) volunteered to be the Nominations Officer.

Midwifery Education in Canada

In Quebec there have been several registered nurses graduate from the midwifery programme. They have done the full 4 years with exemption for 1or 2 courses only. It is difficult to reduce the time because the Canadian program is based on Continuity of Care and each graduate has to have a certain number of completed courses of care where the woman has been known throughout the cycle.

Registered nurses who want to become midwives in less than 3 or 4 years have gone to a country where they offer a post graduate midwifery programme in 1-2 years. They have to ensure that they have had experience in home births in order to be considered for practice in Canada, and they also have to write the examinations. There are many registered nurses who do not have confidence in birth as a normal life process. Many registered nurses have to unlearn their feelings that all births should be "managed".

In the village of Inukjuak, Nunavik (Northern Quebec), there are 2 Inuit midwives and 2 Inuit students. They care for about 50 pregnant women per year, with 70% of the births occurring in the village. They handle all emergencies (including miscarriages, ectopics, etc.) with support from the nurses and doctor when needed. It is a totally collaborative practice that is part of the whole Hudson Bay Health service. There are now 9 Inuit trained-midwives in Nunavik who are responsible for the births in 3 communities. (Also see: 2004/2005 Winter issue of the *Canadian Journal of Midwifery Research and Practice, 3*(3), 36-38.

There is a new program being developed to train aboriginal midwives at the University of Manitoba in conjunction with the College of the Arctic in Iqaluit.

Motions Approved at the Society of Obstetricians and Gynaecologists of Canada (SOGC) Meeting, October 30-31, 2004, Ottawa, Ontario.

MOTION 1 - Access to Maternity Care Services

A Motion was moved: "Whereas all Canadian women should have access to quality obstetrical services;

Whereas it is essential that maternal and neonatal morbidity and mortality be further reduced;

Whereas obstetrical care is not an elective service and both choice of provider and access to services should be protected for all Canadians;

Be it resolved that:

Access to maternity and newborn care be promoted in all Canadian hospitals and that overall regional plan and allocation of resources be established in collaboration with health care providers."

Carried

MOTION 2 -Midwifery Education Programs in Canada

A Motion was moved: "Whereas the critical shortage of primary maternity care providers in Canada is well documented;

Be it resolved that:

1) SOGC supports regulated midwifery education programs in all provinces/territories in Canada.

2) SOGC supports the government funding of regulated midwifery education programs in all provinces/territories in Canada.

3) SOGC recommends the development of accelerated education programs that would allow experienced perinatal nurses to become registered midwives."

Carried.

MOTION 3 - Hospital Privileges for Midwives

A Motion was moved: "Whereas, the SOGC has a policy that supports licensed midwifery practice in Canada;

Whereas, the SOGC supports access for all women and their caregivers in Canadian hospitals;
Whereas, the SOGC is promoting integration of midwifery practices within the collaborative Care Model;
Be it resolved that:
1) Provincial and territorial governments provide all hospitals adequate funding for maternity services including midwifery services.
2) SOGC recommends that Canadian hospitals offer women access to midwifery services without restrictions.
3) Registered midwives be granted admitting privileges in Canadian hospitals with maternity services."

MOTION 4 - Development of Aboriginal Educational Midwifery Programs in Canada
A Motion was moved:
Be it resolved that:
"The SOGC supports the development of midwifery education programs for aboriginal midwives in Canada".

Multidisciplinary Collaborative Primary Maternity Care Project (MCP^2)
Mission
To reduce barriers and facilitate the implementation of national multidisciplinary collaborative primary maternity care strategies as a means of increasing the availability and quality of maternity services for all Canadian women.

Working Definition of Collaboration
"Collaborative patient-centred practice is designed to promote the active participation of each discipline in providing quality patient care. It enhances patient and family-centred goals and values, provides mechanisms for continuous communication among care givers, optimizes staff participation in clinical decision making (within and across disciplines), and fosters respect for the contributions of all disciplines." (Based on Health Canada's definition of collaboration)

Guiding Principles
Mutual trust and respect
Open, honest communication
Shared values, goals and visions
Shared responsibility and accountability
Equality and shared power
Understanding of, and respect for, each other's perspective and way of thinking
Valuing each other's style and scope of practice
Unified front and mutual support
Willingness to devote time and energy to the relationship
Willingness to openly discuss differences
Open and frank discussion of financial issues
Professional competence
Belief that quality maternity care is achieved by the contribution of all care providers

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MANITOBA GOVERNMENT NEWS RELEASE
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December 13, 2004

FIRST ABORIGINAL MIDWIFERY EDUCATION PROGRAM TO BE ESTABLISHED IN MANITOBA

Program to Provide Traditional Aboriginal and Western Methods of Practice

Women in Manitoba will have better access to Aboriginal midwives through a new, innovative $1.6-million training program, Health Minister Tim Sale and Advanced Education and Training Minister Diane McGifford announced today.

"The availability of accredited midwives in Aboriginal communities will help ensure the mother and her baby have access to culturally and medically appropriate maternal and newborn care in their home communities," said Sale. "I want to thank the elders and community representatives for their valuable contributions of knowledge and support. As we move forward, communities will continue to be involved in the development and implementation of this important new program."

The Aboriginal Midwifery Education Program (AMEP) will provide midwifery students with a blend of traditional Aboriginal and Western methods of practice, and will include both classroom and clinical components. When their education is complete, the midwives will provide culturally appropriate birthing services primarily to remote and northern Aboriginal communities in Manitoba and in Nunavut and the Northwest Territories.

"This new program will provide culturally appropriate, community-based education and will be the first Aboriginal midwifery education program in Canada to prepare its graduates for registration with their provincial regulatory body," said McGifford. "The Aboriginal Midwifery Education Program will not only improve access to career opportunities for Aboriginal women, but will also benefit families and communities across Manitoba's North."

"This is an excellent initiative that will greatly benefit the Aboriginal communities. We welcome the opportunity to continue our close relationship with our friends and partners in Manitoba by working together in the implementation of Manitoba's Aboriginal Midwifery Education Program.

We are excited about the obvious potential for collaboration between this program and our 12-year-old Maternal Care Services Program being further developed by our Nunavut Arctic College," Nunavut Health and Social Services Minister Levinia Brown said.

Early in 2005, the Northwest Territories will introduce the profession of midwifery to provide mothers the choice of giving birth in their home communities.

"The Aboriginal Midwifery Education Program will provide northerners the opportunity to receive accredited training," said Northwest Territories Health and Social Services Minister Michael Miltenberger. "I look forward to working with my colleagues in Manitoba to explore how N.W.T. residents can participate in the program and then bring these skills back to their home communities."

"This new Aboriginal Midwifery Education Program is an integral approach towards re establishing our social and cultural heritage," said Assembly of First Nations National Chief Phil Fontaine. "It is extremely important that expectant mothers have the right to deliver their babies in their own communities, in their own homes, rather than in a sterile hospital environment, far removed from their families. "I applaud the Government of Manitoba for taking this innovative step, which is really a rediscovery of First Nations' traditional practices."

"The Aboriginal Midwifery Education Program will take the best from First Nation traditions and from Western medicine, and will give the gift of sharing in the birth of a new life back to First Nation people," said Dennis White Bird, grand chief of the Assembly of Manitoba Chiefs. "It is important that First Nation communities have programs such as the AMEP, but it is also important that they have the infrastructure and access to modern medical tools that will allow our communities to be better prepared to care for our people-starting with their first breath."

This degree-based education program will be delivered by the University College of the North. Ten students will be enrolled in the first year of the program with five students enrolled in each subsequent year.

Manitoba Health, in collaboration with other stakeholders, submitted the AMEP proposal to the Aboriginal envelope of Health Canada's Primary Health Care Transition Fund. The full funding request was approved and was one of 11 proposals approved out of more than 130 submissions.

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BACKGROUNDER

The goals of the Aboriginal Midwifery Education program include:
* addressing maternal and newborn health practices for Aboriginal women, their families and communities;
* ensuring equitable access and quality services for Aboriginal communities and providing services closer to home;
* reducing recruitment and retention issues for health providers in Aboriginal communities;
* increasing the representation of indigenous health care providers in Manitoba; and
* improving health outcomes in Aboriginal communities over the longer term.

The benefits of midwifery:
Midwives provide continuity of care and a wide range of maternal and newborn services. Some of the long-term benefits of midwifery care include the provision of:
* information on diet and exercise that can help reduce the likelihood of a low birth weight baby, the likelihood of complications and the need for costly, invasive medical procedures;
* information on the harmful effects of smoking and drug and alcohol use during pregnancy and their potential to cause complications for the woman and physical and/or mental complications for the baby;
* information on the positive effects of breastfeeding such as long-term health benefits for the baby;
* both physical and emotional support to pregnant women who experience social difficulties such as violence, addictions and poverty; and
* one-to-one care provided by midwives that helps teach women how to be healthy so they will give birth to healthy babies. When a healthy mother gives birth to a healthy baby with a normal birth weight that is breast-fed and provided with appropriate newborn care, the baby has a much greater chance of living a healthy life, thereby reducing costs to the health care system.

Northern regional health authorities have developed a community health centre model where social service agencies and primary health care teams work collaboratively to better serve the population. Midwives will be an integral part of community health services. Midwives working as part of a primary health care team will also partner with other social service agencies and organizations to ensure quality service provision.

Congratulations

Congratulations to Pamela Browne, the AMNL Treasurer, who passed the recent International Board of Lactation Consultant Examination with 'flying colours'. (Recertification by the IBLCE is required every five years to show that the consultant is still competent to practice.)

Congratulations to Kay Matthew, the AMNL Secretary, who was awarded an Honorary Membership by the ARNNL at their October annual general meeting. Also in October, a documentary film at the International Film Festival held in St. John's, showed Kay Matthews going about her Safe Motherhood work in Ghana.

Friends of Midwifery Newfoundland and Labrador is a public awareness and consumer advocacy group working towards the establishment of Midwifery as a self-regulating profession in Newfoundland & Labrador. It was originally formed in June 1994, as a result of the growing interest in the province in the role of the midwife. The Friends of Midwifery NL has recently been reinvigorated. We believe midwives to be an essential part of a comprehensive health care system, and the option of midwifery care to be a right of all women and newborns in this province. For more information please contact Patti McGrath (Volunteer Coordinator) friendsofmidwifery@yahoo.ca Friends of Midwifery NL meeting planned for February 15, 2005, from 7:00 to 9:00 p.m. at Sobey's Community Room, Old Placentia Road, Mount Pearl.

Midwifery in New Zealand

In New Zealand about 73% of women have a midwife as their lead Maternity Carer. A midwife from this province is a midwifery lecturer there. As well as teaching she looks after women during their pregnancy, labour, birth, and postnatally. She will be here for a visit later in the year and would like to talk about midwifery in New Zealand.

Have You Read?

The *RCM Midwives Journal* is now available at the web site: www.ingenta.com

Midwifery and Related Topics

- Aboriginal Health Research and Policy: First Nations-University Collaboration in Manitoba. (2005). *Canadian Journal of Public Health, 96*(Suppl.1).
- Basak, C. (2004, Autumn). What interesting and exciting times we live in . . . that is, if you like change! *RCN Midwifery Connections*, pp. 1, 3. [Professional roles are changing and traditional boundaries between what nurses, midwives, and doctors do, are being shifted and broken down. www.skillsforhealth.org.uk ; www.dh.gov.uk/agendaforchange; www.rcn.org.uk/midwifery; www.healthcarecommission.org.uk; www.parliament.the-stationery-office.co.uk/pa/cm/cmsctech.htm .]
- Bhopal, R. (2004). Glossary of terms relating to ethnicity and race: For reflection and debate. *MIDIRS Midwifery Digest, 14*(3), 413-418. [From the June 2004 issue of the *Journal of Epidemiology and Community Health, 58*(6), 441-445.]
- Clinical Issues. (2004). Nutrition in women and newborns. JOGNN, 33(6), 800-832.
- Day-Stirk, F. (2005). 2005 - back to the future? *RCM Midwives Journal, 8*(1), 4. [The history of midwifery confirms that once-accepted models have now been overturned and replaced with new ones. As a profession we have to constantly review where we are going. A profession is a 'Superior, non-manual type of occupation, requiring advanced education and training. Has a specific, exclusively owned body of knowledge and expertise. Organises and controls itself by establishing standards of ethics, knowledge and skills for licensed practitioners. Lacking these, people will not be admitted into its ranks. A profession is also recognised as such by its members and by society at large' (Oakley, 1993). While maternity services remain within the acute sector women will continue to receive inadequate care because of the shortage of midwives, and midwives will leave because of a lack of job satisfaction.]

- Denton, J. (2004, Autumn). Part three: When a twin or triplet dies - the role of the midwife. *Midwifery Connections*, pp. 4-5. [More twins and triplets than singletons die. www.multiplebirths.org.uk .]
- Ebenezer, C. (2004). Guide to current awareness services. *RCM Midwives Journal, 7*(9), 399. [Some electronic services require accounts, but unrestricted access is available at www4.infotrieve.com/journals/toc_mail.asp where the lists of contents are available for more than 20,000 journals. The NurseLinx Perinatal Newsletter is available at www.mdlinx.com/NurseLinx/index.cfm . It provides useful coverage of midwifery, obstetric and specialist nursing literature, including updates to Cochrane Reviews, although much of the material covered is subscription-based. A weekly newsletter providing an independent source of health informatics new is www.e-health-insider.com/index.cfm]
- Ebenezer, C. (2004). RCM Midwives Journal: Electronic access. *RCM Midwives Journal, 7*(11), 479. [The publishers, McMillan-Scott, have moved the journal's web site to www.ingenta.com and by entering *RCM Midwives Journal* into the search box one can access many of the articles. The full text files are in HTML or PDF formats and can be down-loaded or emailed to another computer. Many of the articles are free of charge. There is an embargo on the previous six months so as to preserve the College membership. At present the journal issues are available back to 2002, but plans are for back issues to be available from 1998.]
- McKenzie, K. (2004). Mentoring: It's a two-way street. *RCM Midwives Journal, 7*(12), 526-528. [Students' clinical placements can vary greatly in how positive they are and this is often due to the mentoring received throughout. Students write how the provision of support and the quality of relationships formed with trained staff are seen as crucial factors in the creation of a positive learning environment for students. There is also a need for open communication and feedback so that the mentor knows whether the student is receiving needed information.]
- Mullally, S., & Way, S. (2004). Challenges and changes. *RCM Midwives Journal, 7*(11), 480-481. [On August 1, 2004, the new register for nurses, midwives and specialist community public health nurses opened. There are new rules and standards for all parts of the register. The NMC (which took over from the UKCC) will undertake a number of pieces of work that will have an impact on the education, practice and supervision of midwives. These include: Review of the pre-registration midwifery content and competencies; Review of the standards for midwives returning to the register; Policy review for overseas trained midwives applying for UK midwifery registration; Review of the standards for midwives remaining on the register; Development of a framework for practice beyond initial registration. Consultations will be available on the NMC website: www.nmc-uk.org.]
- Silverton, L. (2004). Occupational standards for maternity care. *RCM Midwives Journal, 7*(9), 364. [In 2002 Skills for Health was established as the sector skills council for health across the UK. They have recently completed work on behalf of the Children's National Workforce Competence Framework. The second phase of this work is now looking at occupational standards for maternity and care of the newborn. National Occupational Standards are statements of competence defined in a different way from those used by the NMC. They apply to all staff groups (including doctors). It has been pointed out to the

project team that the 'protection of function' enshrined in legislation (that reserves to midwives and doctors the privilege of attending a woman in childbirth) and the definition of the role of the midwife, will limit the extent to which different staff groups can participate in the provision of maternity care. It is also important to ensure that this work complements that already undertaken, such as the *Agenda for Change: Knowledge and Skills Framework*, the RCM (2002) documents on *Refocusing the Role of the Midwife* and the associated guidance paper, as well as the curriculum for maternity care assistants launched in May 2004.]

- Thomas, M. (2004). The future of midwifery: Steering a course. Sixth Zepherina Veitch lecture. *RCM Midwives Journal, 7*(10), 430-434. [The presenter of this memorial lecture considered the journey that lies ahead for the midwifery profession. Midwives are experts in normality. It is what our educational and practical preparation is based on and is what we are meant to maintain throughout our career. Physicians do not say that they are unable to embrace and practice a skill in a new way or in a new setting, so why do midwives feel nervous about their role and the environment in which they practice? Midwifery led care should always be about doing what is in the best interests of the woman and her family. Giving as much choice as possible based on evidence and in the light of individual needs and circumstances. Partnership-working is the key to success. To lead woman-centred care, develop appropriate models and frameworks of care across diverse services and within competing priorities, requires more midwives. In the UK they are fortunate to have self-regulation through the Nursing and Midwifery Council. There is also statutory supervision of midwives and of midwifery practice. Midwives need to understand the requirements in order to justify being an autonomous practitioner. Midwives need to be aware of national trends and policy, knowledge obtained from local data, needs and opportunities. Then with a good action plan midwives can be armed for a successful journey.]
- Thompson, A. (2004). Bridging the gap: Teaching ethics in midwifery practice. *MIDIRS Midwifery Digest, 14*(3), 304-309. [From the May/June 2004 issue of the *Journal of Midwifery and Women's Health, 49*(3), 188-193. Translating ethical thought and reflection into action - bridging the theory-practice gap - is a perennial challenge. This article presents some of the tools available to professionals to use. To enable midwives to make or help others make critical decisions that will impact lives.]
- Walker, J. (2005). Informed choice and the concept of risk. *RCM Midwives Journal, 8*(1), 40-41. [The way in which the use of technology, such as continuous fetal monitoring, has been embraced, while the continuous presence of a midwife has not, highlights how we have been seduced into a technological belief system where women's bodies are not trusted. Some women have an intuitive feeling fo their baby's growth and wellbeing, while others need the reassurance of technology. Women lead complex lives and often the consideration of a procedure or risk is put into this context. A busy professional woman may see a cesarean section as away of being in control, as the date can be entered into her diary.]
- West, M., & Sacramento, C. (2004). Building successful teams: Sparkling fountains of innovation. *RCM Midwives Journal, 7*(9), 386-389. [The advantages of working in a team and valuing each member is discussed. In order to be effective and sustain minority influence, the vision must be one that motivates and inspires team members - a future they really feel is worth fighting for.]

Pregnancy

- Armstrong, D. S. (2004). Impact of prior perinatal loss on subsequent pregnancies. JOGNN, 33(6), 765-773. [A survey of 40 pregnant couples who had experienced a prior perinatal loss, found that the extent to which the impact of the prior loss increased parents' stress in the current pregnancy influenced their psychological distress.]
- Herschderfer, K. (2004). WHO, ICM and FIGO launch: 'Making Pregnancy Safer: The critical role of the skilled attendant'. *ICM International Midwifery, 17*(6), 65. [www.who.int/reproductive-health/publications/2004/skilled_attendant.pdf]
- Lee, B. (2004). Ill mothers and critical care: The challenge in the 21st century. *RCM Midwives Journal, 7*(12), 522-524. [This is a report of a meeting of the Forum on Maternity and the Newborn of the Royal Society of Medicine held June 17, 2004. The report appears in full on the Forum's website at www.motherhood.org.uk .]
- Little, J., Cardy, A., & Munger, R. G. (2004). Tobacco smoking and oral clefts: A meta-analysis. *MIDIRS Midwifery Digest, 14*(3), 329. [From the March 2004 issue of the *Bulletin of the World Health Organization, 82*(3), 213-218. The conclusion of the study was that the evidence of an association between maternal tobacco smoking and orofacial clefts was considered by the researchers to be strong enough to justify its use in anti-smoking campaigns. A woman has approximately a 30% increased risk of having a child with CL+/-P and a 20% increased risk of having one with CP if she smokes during pregnancy. This article which is claimed to be very important was originally published in a journal which is probably not widely read, especially by midwives.]
- Sprague, A. E. (2004). The evolution of bed rest as a clinical intervention. *JOGNN, 33*(5), 542-549. [The history of bed rest is explored. It seems that it evolved from a little is good to a lot is better, which is not supported by research findings. Evidence from randomized trials is urgently needed to augment the descriptive, exploratory, and quasi-experimental data that already exist.]

Genetics

- Hansen, S., Gardulf, A., Andersson, E., Lindqvist, M., & Gustafson, R. (2004). Women with primary antibody deficiency requiring IgG replacement therapy: Their perception of prenatal care during pregnancy. *JOGNN, 33*(5), 604-609. [An important part of human immune defense is the production of antibodies by the B-lymphocytes. The antibodies recognize and combat infectious microbial agents such as bacteria and viruses. The antibodies are divided into five main classes, immunoglobulin G, A, M, D, and E. IgG is divided into four subclasses. A lack or low levels of IgG, IgA, and/or IgM lead to an increased frequency of bacterial infections. Primary antibody deficiencies (PAD) are naturally occurring defects of the B-lymphocytes to produce antibodies, which remain for life. The full complexity of PAD is not yet completely understood. Only for a few conditions such as X-linked agammaglobulinemia (XLA), a congenital form of PAD, has the defective gene been isolated and characterized. In women with normal immune systems and normal levels of serum antibodies, IgG is normally transported from the maternal blood circulation across the placenta to the fetus during pregnancy. The fetal IgG concentration is extremely low in the beginning of pregnancy but increases proportionally with gestational age. The active placental transport is essential to ensure that newborns have sufficient IgG levels at birth, as they synthesize insufficient amount of antibodies on their own during the first months of life. For women with PAD an

adequate replacement IgG therapy with increasing IgG dosages during pregnancy is essential to prevent infections and maintain well-being. The IgG volume (weekly dosage of 100 mg/kg body weight) needs to be adjusted according to the mother's increased body weight. In this Swedish small study, the women were not satisfied with prenatal care and reported that physicians and midwives lacked knowledge about PAD and IgG therapy. Increased knowledge is needed to prevent misleading advice that puts the health of the mother and her fetus at risk.]

- Lemon, B. S. (2004/2005). Nuchal translucency for prenatal screening? *AWHONN Lifelines, 8*(6), 520-526. [Nuchal translucency (NT) refers to the ultrasonographic finding of an abnormal collection of fluid behind the fetal neck extending from the occiput to the upper posterior part of the spine. A measurement of more than 3 mm between 10 and 14 weeks gestational age is considered abnormal, as it may be a sign of cardiac or chromosomal abnormality being present. An increased NT measurement in combination with maternal age and maternal history, fetal crown-rump length, and the triple screen tests (maternal alpha fetoprotein, human chorionic gonadotropin, and unconjugated estriol) has been reported to identify 97% of fetuses with Down syndrome. Amniocentesis has some drawbacks as there is a waiting time while the amniotic fluid is tested, the procedure in not usually performed before 14 to 16 weeks of pregnancy, and the risk of fetal loss is approximately 0.5%. Chorionic villus sampling is usually performed at 10 to 12 weeks of pregnancy but there is a 1% to 2% risk of limb and oromandibular defects, and about 0.6% to 0.8% risk of fetal loss. Women should be given ample opportunity to ask questions, to be aware that the test may be refused, and to be able to make an informed choice.]

<u>Labour and Birth</u>

- Anderson, T. (2004). Time to throw the waterbirth thermometer away. *MIDIRS Midwifery Digest, 14*(3), 370-374. [Babies born into warm water do not receive the multiple stimuli to breathe simultaneously, and effective gas exchange may be slower to establish. In some places in Germany they purposely lower the water temperature during second stage to 34 degrees Celsius. The cord needs a cold stressor response, amongst many factors, to stop it pulsating, so a lowered water temperature may also be beneficial for the delivery of the placenta. A study of 3,162 waterbirths and 5,272 landbirths found that waterbirth babies had less morbidity than the landbirths, Neonatal temperatures remained similar in both groups. For note recording it could be stated that 'water temperature adjusted for maternal comfort'. It is suggested that other papers should be studied: Geissbuehler et al. *Journal of Perinatal Medicine, 32*, 308-314, and Grunebau & Chervenak, *Journal of Perinatal Medicine, 32*, 306-307.]
- Buckley, S. J. (2004). Labour and birth: What disturbs birth? Part 2. *MIDIRS Midwifery Digest, 14*(3), 353-359. [A previous version of this paper was published in the 2003 *Journal of Prenatal and Perinatal Psychology and Health, 17*(4), 261-288. This is a continuation of the previous article examining the part of hormones on birth and mothering, and the hormones which effect the baby's adaptation to life after birth. For example, synthetic oxytocin is different from natural oxytocin, and oxytocin, however produced, cannot cross the "blood-brain barrier" and so cannot act as the hormone of love. Synthetic oxytocin does not increase the beta endorphin levels in labour, neither do epidurals [Your Editor: But, the two are often given together]. Researchers have found

that mothers who received analgesics in labour were more likely to have children who became drug addicts. Cesarean sections effect the mothers mood and self esteem whereas forceps and vacuum extractions do not. Early breastfeeding results in hormone release, some of which stimulate the growth of intestinal villi in the mother and the infant, and so more nutrient absorption. Also, see the article: Giving Birth: The Endocrinology of Ecstasy on the web site: http://www.byronchild.com/arts13.htm]

- Hundley, V., & Ryan, M. (2004). Are women's expectations and preferences for intrapartum care affected by the model of care on offer? *MIDIRS Midwifery Digest, 14*(3), 359-361. [From the 2004 *British Journal of Obstetrics and Gynaecology, 111*, 550-560. The consumer may not automatically seek sensitive service delivery. Women are socialised into a maternity system that is less than beneficial for women and midwives. Managers and policy-makers may be tempted to maintain the status quo if women do not appear to have strong preferences for change. Women and their families need to fully understand the issues involved in delivery options.]
- Kennedy, H. P., & Shannon, M. T. (2004). Keeping birth normal: Research findings on midwifery care during childbirth. *JOGNN, 33*(5), 554-560. [In this qualitative study the midwives believed that birth is normal, and many of their activities were specifically aimed toward the support of it as a physiologic, rather than pathologic, process. One of their approaches was to work with women, nurses, students, and physicians to understand and hopefully assimilate this belief. Many women were surprised at how painful, long, and challenging labour can be and came to doubt their ability to get through it.]
- Lee, B. (2004). Normal birth. Is it possible in the 21st century? *RCM Midwives Journal, 7*(9), 396-398. [This is Part 1 of the meeting of the Forum on Maternity and the Newborn of the RSOM held on April 22, 2004. Professor Jim Thornton of the Nottingham University and City Hospital, spoke on hands off - a new approach to labour. Natural labour is only achieved by avoiding interventions. For first labours, when there is a 'delay' before 4 cm cervical dilatation it is ignored. If the membranes are intact and there is no fetal distress, observe indefinitely. Diagnose full dilatation by inspection only, vaginal examinations (VE) will never be done more frequently than every four hours, and never left for more than 12 hours. VE is deferred until the findings would prompt a cesarean section. The result is that very few vaginal examinations are needed. A woman admitted with cervical dilatation of 4 cm might take 22 hours to reach full dilatation (16 hours to reach 8 cm and a further six hours to full dilatation). Then with a two-hour second stage, this give a maximum of 24 hours in labour. Mary Cronk spoke on a midwife's approach to vaginal breech delivery.]
- Lee, B. (2004). Normal birth. Is it possible in the 21st century? *RCM Midwives Journal, 7*(10), 440-442. [This is Part 2 of a meeting report of the Forum on Maternity and the Newborn of the RSOM, held April 22, 2004. The full report is on the Forum's website at www.motherhood.org.uk. Jenny Smith used triangles as a framework, when she spoke on "Twins, mothers and midwives - working with mothers of twins in labour". Midwives can provide good support in labour, offering choices that empower women to give birth to their babies normally. But, midwives are losing the art and skill to care for these women in labour. Too often fragmented, impersonal care puts the twins at the centre of all interactions and treats the woman as merely a vehicle for the gestation. Bernadette Matus spoke on "Mind your language - exploring positive communication skills". Too often

words used have connotations of the woman being at fault, e.g. trial of labour, not having proved that you can deliver, it's your decision but no you can't do this, your only x centimetres dilated, incompetent cervix (but men are not told that they have an incompetent penis), and other terms. Examinations are often performed without asking the woman's permission. Midwives can empower women and be their advocates. Trefor Roscoe spoke about "Information is power - finding your way round the web". The integration of internet information into care has led to the creation of the electronic patient record. A RCM survey (2003) showed that 10% of practising midwives had no computer access, 60% only had shared or difficult access. Ten recommendations arose from the survey, including that all midwives should have access.]

- Priddy, K.. D. (2004). Is there logic behind fetal monitoring? *JOGNN, 33*(5), 550-553. [Continuous electronic fetal monitoring (EFM) commenced in the late 1960s. It was started as a way of improving birth outcomes, but this has not happened. Instead, there has been a significant increase in the rate of cesarean sections, operative vaginal deliveries, and of litigation, as a result of EFM. Nine research studies including 18,561 subjects show that there is no significant benefit to the use of EFM, but there are significantly more operative deliveries associated with its use. The presence of a skilled, supportive caregiver provides multiple benefits. But, we are attached to technology and so add another procedure, fetal pulse-oximetry. A recent Cochrane review concludes that due to the lack of randomized trials for fetal pulse-oximetry, there is still insufficient evidence to support its use.]
- Woodward, J., & Kelly, S. M. (2004). A pilot study for a randomised controlled trial of waterbirth versus land birth. *MIDIRS Midwifery Digest, 14*(3), 361-369. [[From the June 2004 issue of the *British Journal of Obstetrics and Gynaecology, 111*(6), 537-545. This study contained a 'preference arm' to compare the characteristics and the outcomes of the women who were randomised with those who joined the 'preference arm'. The recruiting was carried out a part time midwife, and the few hours in which she was available to recruit participants is questioned. Not all midwives caring for the mothers completed the necessary samples. Five women actually commented negatively on the involvement of the clinical midwives. Were they too busy to be involved in the research requirements? This needs to be examined in a larger study, as does the question as to whether or not choice is integral with satisfaction.]

<u>Infections</u>

- Wang, F-L., Larke, B., Gabos, S., Hanrahan, A., & Schopflocher, D. (2005). Potential factors that may affect acceptance of routine prenatal HIV testing. *Canadian Journal of Public Health, 96*(1), 60-63. [The higher rates of acceptance under the opt-out policy for prenatal HIV screening, particularly in Newfoundland and Alberta have attracted attention. In 2000, Alberta women and their care providers were studied. It was noted that there is a greater likelihood of declining prenatal HIV testing among First Nations women, especially those aged 20-24 years. A lower acceptance among women for those receiving care from female physicians and midwives. There is an increasing trend to the belief that HIV testing should be part of routine optimal prenatal care for all pregnant women. The Institute of Medicine of the US National Academy of Sciences recommends "that pre-test counseling consist primarily of notification that HIV testing is a regular part

of prenatal care for everyone, and that women have a right to refuse it". The refusal should be documented in the patient's medical record to protect the provider from liability. Women found to be HIV-positive should receive extensive "post-test" counselling and be referred for treatment for themselves and to prevent perinatal transmission.]

- Wener, M. E., & Lavigne, S. E. (2004). Can periodontal disease lead to premature delivery? How the mouth affects the body. *AWHONN Lifelines, 8*(5), 422-432. [With bacterial infections implicated as the cause in 30% to 50% of the births of all preterm low birth weight (PTLBW) babies, researchers speculate that sites of infection distant from the placenta, such as the mouth, might contribute to PTLBW. Periodontitis is chronic and often painless, so individuals frequently do not realize they have the disease. Risk factors for periodontitis are: poor oral hygiene and lack of routine professional dental care; lack of routine professional dental care; low socioeconomic status; immuno-compromise; smoking; diabetes; genetic predisposition. The primary cause of periodontitis is microbial oral biofilm or plaque. Gram negative organisms are the microorganisms most commonly associated with periodontitis. These are the organisms which cause the release of cytokines, which trigger the release of prostaglandins, resulting in the onset of labour. At the start of pregnancy all women should be advised to seek professional dental care for a thorough assessment. The article is illustrated with coloured photographs.]

Postpartum Care

- Pollock, L. (2004). SUI after childbirth. *RCM Midwives Journal, 7*(12), 504. [Stress urinary incontinence affects many women after childbirth, but is seldom discussed. Women's Environmental Network (WEN) has a briefing paper, *No laughing matter: Stress incontinence and the environment*, available at www.wen.org.uk/continence/index.htm Wen says the prevalence of stress incontinence during pregnancy ranges from a quarter to two-thirds, and after childbirth from 6% to 31%. A large baby and the likelihood of an episiotomy are an indication that a woman will be affected.]

Neonatal Care

- Bryanton, J., Walsh, D., Barrett, M., & Gaudet, D. (2004). Tub bathing versus traditional sponge bathing for the newborn. JOGNN, 33(6), 704-712. [In this PEI study 100 mothers were randomly assigned to an experimental tub bath or a sponge bath control group. Tub-bathed babies experienced significantly less temperature loss and were significantly more content than those who were sponged bathed. The mothers of tub-bathed babies rated their pleasure higher than did mothers of sponge bathed babies. No differences in maternal confidence were noted. There were no differences in cord healing scores.]
- Patel, H. & Beeby, P. J. (2004). Resuscitation beyond 10 minutes of term babies born without signs of life. *MIDIRS Midwifery Digest, 14*(3), 391-393. [From 2004 *Journal of Paediatrics and Child Health, 40*, 136-138. After studying the records of 29 term babies with a 10 minute Apgar score of 0, 100% died or had disabilities. Therefore, discontinuation of resuscitation is recommended at this time interval.]

Breastfeeding

- Quillin, S. I. M., & Glenn, L. L. (2004). Interaction between feeding method and co-sleeping on maternal-newborn sleep. *JOGNN, 33*(5), 580-588. [Breastfed newborns had less total sleep per day than bottle-fed newborns, and breastfeeding mothers had more sleep periods in 24 hours than bottle-feeding mothers. Breastfeeding mothers slept more than bottle-feeding mothers when co-sleeping, but bottle-feeding mothers' sleep was unaffected by location of newborn. Average total sleep for 4-week-old newborns was about 14 hours daily. Methods or devices that allow breastfeeding mothers and newborns to sleep next to each other in complete safety need to be developed.]

Family Planning

- Overweight women on the pill are more likely to become pregnant, U.S. researchers said, one explanation being that the amount of estrogen in modern contraceptives may not be enough for some. The pill is said to be 99 per cent effective, though only if taken properly. The U.S. study suggested that of 100 women on the pill, an extra two to four would become pregnant due to being overweight. ((2005, January 10). *Maclean's, 118*(2), 17).

Women's Health

- Ashcroft, T. (2004/2005). Clinical preventative services for men. Information for women's health care providers. *AWHONN Lifelines, 8*(6), 528-533. [Women attending women's health clinics may ask for advice about their partner's health. Men are often at risk for lifestyle issues, and screening is recommended for prostate and colorectal cancers, high blood pressure, cholesterol, obesity and diabetes. Recommendations vary according to the individual's age and risk factors.]
- Clinical Issues. (2004). Youth is a gift of nature, but aging is a work of art: Health issues of older women. *JOGNN, 33*(5), 626-670.
- The cholesterol cure. (2004). *Maclean's, 117*(43), 22-28. [Statins, part of a $28-billion-a-year global market, are one of the reasons Canada's mortality rate from heart disease has been declining, and is now 79,000 persons per year. Statins also appear to show benefits for several other illnesses. In Britain the statin with a long track record, Zocor, may be bought over the counter at pharmacies. Statins do not interact well with some antibiotics, and they can cause birth defects, so they should not be taken by pregnant women. Some patients have complained of headaches, nausea and a decrease in sexual libido. They may also cause muscle weakness. Rhabdomyolysis, a muscle-tissue breakdown that causes kidney failure.]

Nutrition

- Egeland, G. M., Berti, P., Soueida, R., Arbour, L. T., Receveur, O., & Kuhnlein, H. V. (2004). Age differences in vitamin A intake among Canadian Inuit. *Canadian Journal of Public Health, 95*(6), 465-469. [Vitamin A is important for immune function, gene expression, reproduction and embryonic development, growth and normal vision with both excessive and inadequate intakes having adverse health impacts. The developing fetus is particularly sensitive to suboptimal and excessive exposures. Suboptimal vitamin A intake has been noted in many northern communities and has been postulated to lay a

role in the high rate of infections and respiratory illness among Inuit children. Eighteen communities were selected for dietary surveys in 1998-1999, which included a 24-hour dietary recall questionnaire, a 7-day record, and a 3-month frequency questionnaire regarding traditional food. A total of 715 men and 909 women participated. More young people between 15 and 40 years of age had inadequate intakes of vitamin A, and they consumed less liver, than older Inuit. Low vitamin A intake may be more deleterious in northern communities where there is a high prevalence of binge drinking. Adverse effects of inadequate and excessive vitamin A exposures on the developing fetus is likely to be more pronounced among women who drink excessively and have had a history of alcohol abuse. Ethanol ingestion alters vitamin A metabolism and depletes vitamin A liver stores. This metabolic interaction has been postulated to play a role in the pathogenesis of fetal alcohol syndrome. The US Centers for Disease Control advises that liver can be consumed in moderation during pregnancy, and this is what the researchers recommend.]

Research Methods

- Cesario, S. K. (2004/2005). Research into practice. Evaluating Friedman's labor curve and assessing the "normal" length of labor. *AWHONN Lifelines, 8*(6), 506-510. [Friedman's labor curve (1954) is based on flawed research. The weaknesses include a small sample of only 100 white women in their early twenties. The start of labour was calculated based on subjective reports by the women. Many of the women were medicated with morphine and scopolamine and some were delivered by forceps. There was no geographic, ethnic, racial, socioeconomic, or provider diversity in the sample. Fetal assessment techniques were virtually nonexistent in 1954, and since then educational preparation and responsibility of the nurses in labour and delivery have increased dramatically. Now the use of delayed and nondirective pushing techniques may delay the second stage of labour beyond the two-hour time limit. Women are encouraged to use a variety of positions for birth which may hasten the second stage. Recognizing that there are three phases of the second stage of labour and knowledge of the physiologic processes of each stage results in more effective care. While Friedman's Labor Curve was an excellent tool in the 1950s it is time to recognize its limitations and identify other means to assess labour progress and plan interventions based on individualized fetal and maternal well-being, not rigid time constraints. Education of the general public is also necessary to reassure the family that labour is progressing safely, even if it seems to be taking a little longer than anticipated.]
- Cesario, S. K. (2004). Reevaluation of Friedman's labor curve: A pilot study. JOGNN, 33(6), 713-722. [Surveys were mailed to 500 maternity care agencies in the United States, Canada, and Mexico. Each participating agency was asked to submit five patient cases to be included in the analysis. The 419 women in the study received no regional anesthesia or oxytocin augmentation or induction. Twenty three percent of the women were primigravidas. The average length of labour for primiparous and multiparous women is similar to the average length described by Friedman in 1954, but there was a wider range of "normal". Primiparous women remained in the first stage of labour for up to 26 hours and the second stage of labour up to 8 hours (average length was 54 minutes) with good outcomes. Multiparous women were in first stage of labour for up to 23 hours and the second stage of labour for up to 4.5 hours (average length was 18 minutes) with good birth outcomes.]

- Grady, P. (2004). Annotated bibliography of National Institute of Nursing Research findings on Women's Health: Articles published since 2002. National Institute of Nursing Research, National Institutes of Health, and the US Department of Health and Human Services. JOGNN, 33(6), 791-799.
- Sakala, C. (2004). Resources for evidence-based practice, September/October 2004. *JOGNN, 33*(5), 622-625. [Some new listings on the Cochrane Data base are listed.(Abstracts are free at www.cochrane.org/reviews). Recent abstract entries assessing quality of systematic reviews are also given for DARE.(Free from www.york.ac.uk/inst/crd/darehp.htm). Evidence-based reviews from other sources are listed.]

Alternatives

- Isbell, B. (2004). Finding the right complementary therapies course. *MIDIRS Midwifery Digest, 14*(3), 404-407. [From the May 2004 issue of the *Complementary Therapies in Nursing and Midwifery 10*(2), 92-96.]
- Tiran, D. (2004). Viewpoint - midwives' enthusiasm for complementary therapies: A cause for concern. *MIDIRS Midwifery Digest, 14*(3), 302-303. [From 2004 *Complementary Therapies in Nursing and Midwifery, 10*, 77-79. Midwives are in danger of overstepping the boundaries of their professional accountability. In an injudicious sense of urgency to offer another element of women-focused care they are not paying due regard to the professional, legal, ethical and interdisciplinary issues to be considered as part of the implementation process. When introduced into the maternity unit, this is normally done in accordance with NMC regulations and midwifery managerial and supervisory support. But some midwives working in isolation use essential oils without explicit permission of their employing authority. Sometimes techniques are used which are not correct, and some midwives use aggressive coercion to get colleagues to use complementary therapies for which they are not trained.]

Weight gain predicts cesarean regardless of birthweight

Source: Obstetrics & Gynecology 2004; 104: 671-7

Assessing to what degree the relationship between weight gain and cesarean birth is explained by macrosomia. Excessive weight gain during pregnancy is independently predictive of cesarean delivery, even when birth weight is not excessive, study findings show. Moreover, "although macrosomia was a stronger predictor of cesarean than weight gain alone, excessive weight gain was much more common than macrosomia in our cohort," say Naomi Stotland (University of California, San Francisco, USA) and co-authors. The team examined how the association between excessive weight gain and cesarean birth was modified by infant birth weight in a retrospective cohort of 9788 singleton, term pregnancies in nulliparous women without diabetes. In a multivariate model that included birthweight, women whose gestational weight gain exceeded Institute of Medicine recommendations had an odds ratio of 1.4 for cesarean birth, compared with those whose weight gain was within the guidelines. Indeed, even among women whose babies weighed less than 4000g, excessive weight gain was associated with a significantly increased risk of cesarean birth. "Other mechanisms besides macrosomia may be involved in the association between high weight gain and cesarean birth," suggests the team. [ObGynWorld.com]

Conferences As this information comes from a variety of sources the editor takes no responsibility for any errors.

2005

March 2-3, 2005. Atlantic Fetal Alcohol Spectrum Disorder (FASD) Networking Conference, Moncton, NB. Hosted by the VON Healthy Baby & Me Project.
Contact: Christine LeBlanc, Provincial Coordinator, VON Healthy Baby & Me Project (Telephone: 506-387-6254).

March 8-11, 2005. "RCN International Nursing Research Conference", Belfast, Northern Ireland.
Contact: Kathryn Clark, Assistant Conference & Events Manager, Royal College of Nursing, 20 Cavendish Square, London W1G 0RN (E-mail: research@rcn.org.uk; Web-site: www.rcn.org.uk/events)

March 17, 2005. "The management of early pregnancy complications and the perils of ectopic pregnancy". Joint RCN and Ectopic Pregnancy Trust conference, London, UK. Objectives are to raise awareness of ectopic pregnancy and its causes. Diagnosis of early pregnancy complications. Chlamydia and the impact on fertility.
Cost: RCN member £85/non-member £105.
Contact: Jeanette Staddon, Royal College of Nursing, Copse Walk, Cardiff Gate Business Park, Cardiff CF23 8XG, Wales. (Telephone: 011-44-29-2054-6493; Fax: 011-44-29-2054-6495; E-mail: womenshealth@rcn.org.uk ; Web-site: http://www.rcn.org.uk/events)

April 19, 2005. "How to carry a Caseload without Breaking your Back. Exploring the Myths, Exploring the Options", Birmingham, England. Plenary sessions and Concurrent sessions.
Cost: Before March 18: MIDIRS/IMA members £65; nonmembers £70. After March 18: members £72; nonmembers £77 (includes lunch and refreshments)
Contact: MIDIRS, 9 Elmdale Road, Clifton, Bristol, BS8 1ZZ,England. (Fax: 011-117-925-1792; E-mail: cturner@midirs.org ; Web site: www.midirs.org or www.independentmidwives.org.uk).

April 28-29, 2005. "Advances in Reproductive Health: Impacts and Outcomes", annual IWK Health Centre's Women's and Newborn Health Conference, Halifax.
Contact: Angela Fraser, Chair of Registration, Women's and Newborn Health, IWK Health Centre, 5850/5980 University Avenue, PO Box 9700, Halifax, NS B3K 6R8 (Telephone: 902-470-6943; Fax: 902-470-8101; E-mail: angela.fraser@iwk.nshealth.ca)

May 5, 2005. **International Day of the Midwife**

May 18-22, 2005. "Reclaiming the Joy of Midwifery and Birth", Copenhagen, Denmark.
Contact: Midwifery Today Inc., P.O. Box 2672, Eugene, OR 97402, USA (Telephone in Canada: 800-743-0974; E-mail: conference@midwiferytoday.com ; Web site: www.midwiferytoday.com)

June 10-16, 2005. American College of Nurse Midwives Annual Meeting, 50th Anniversary.
Contact: ACNM, (Telephone: 240-485-1800; Web site: http://www.midwife.org)

July 24-28, 2005. "Midwifery: Diverse Pathways to Healthy Nations", ICM 27th Triennial Congress, Brisbane, Australia. Speakers include Mina Talaguk from Nunavut, and midwives from Malawi, England, Australia. See information on www.icm-congress.com
Contact: midwives2005@meetingplanners.com.au

August 1-7, 2005. **World Breastfeeding Week**

September 18-21, 2005. "Mapping the Future of Public Health: People, Places and Policies", Canadian Public Health Association 96th Annual Conference, Ottawa.
Abstract: For papers and posters due before February 25, 2005. Competition for student awards.
Contact: Canadian Public Health Association, 400-1565 Carling Avenue, Ottawa, ON, K1Z 8R1 (Fax: 613-725-9826; E-mail: conference@cpha.ca , Web site: www.cpha.ca .)

October 1-7, 2005. **Canada Breastfeeding Week.**

October 22-November 6, 2005. "Midwifery in China". Explore midwifery in China and visit Beijing, Shanghai, Suzhou, Xian, Guilin, with Cathy Warwick, General Manager of Women and Children's Services at Kings College Hospital in London, accompanied by Cheung, Master Travel's national guide.
Contact: Master Travel, Freepost (SE 7045), London SE24 9BR, England. (Fax: 011-44-20-7978-8322; E-mail: tours@mastertravel.co.uk; Web site: www.mastertravel.co.uk).

November 9-11, 2005. CAM conference, Halifax.

Book Review

Worth, Jennifer. (2002). *Call the midwife*. Twickenham: Merton Books, P.O. Box 279, Twickenham, UK, TW1 4XQ ISBN 1-872560-10-5. (£14.99). Through www.amazon.com this book is $23.99. It is noted that a definition of a midwife is given on this web site and it states that a midwife is always a nurse. Of course this is not true in Canada, or Britain, or in the USA, and is not in the International Definition of a Midwife. A person may take a recognized midwifery programme without having any prior qualifications.

This 294 paper covered book is written by a midwife who completed her training in the 1950s. She finished her Part 2 SCM (the old British qualification of State Certified Midwife) in the dockland area of the east end of London. For anybody who trained in London in this era, this book will bring back memories, of tenement buildings with washing flapping on the balcony and in the court yard, the toilet for the whole building in the court yard, and in some places there was a tap on the balcony shared by several families. Others lived in two-up-and-two-down terraced houses, which may have been shared with another family. Girls got married young and "settled down" to produce large families, often while living in two rooms.

The women bought underwear to wear to the antenatal clinic, and then when they got home the knickers were taken off and put away until the next clinic visit. During the birth the bed was usually covered with a sheet bought for the occasion, and the mattress was covered with brown paper and newspaper. Newspaper was put on the floor. A saucepan of water was put on the stove so that there was hot water for bathing the mother and baby. The children were turned out to play until everything was cleared up and then they could return. While the midwife waited

during the labour she was usually offered 'door-step' bacon sandwiches and strong tea from a cup which may never have been properly washed. The "flying squad" could be called if there was a major problem, which seldom ocurred.

The family doctor would attend if the midwife assessed the mother and thought that there could be a problem. Births took place at home because many hospitals had previously been workhouses and women did not want to be admitted to them. Also, there were many immigrants arriving who were very pregnant. They were admitted to hospital as their obstetrical history was unknown, and they may not have got their own accommodation.

The east-end of London was a 'rough area', but if the midwife was wearing her uniform all street fights would stop and the men would step aside to let her pass, and then would continue to settle their grievances. The midwife rode a bicycle with her equipment strapped to the back and the front, sometimes through the "pea-soup" smog which used to occur in London before smokey coal fires were banned. There was less traffic in those days and the roads could be quiet at night. The midwife could be awake all night but then she still had her home visits to carry out, for swabbing and checking the new mother and baby, and prenatal clinics to attend.

The prostitutes often had back-street abortions and if they were allowed to carry their baby to term they went to a house run by their "establishment" to give birth. The baby would then be adopted. There were also mission hostels where unmarried girls could go to wait out their pregnancy. Most babies were given up for adoption as there was a stigma to having a baby prior to marriage, or to having a baby that did not belong to the husband.

This is the setting for this book, and the writer describes home births when the mother had pre-eclampsia, breech birth, premature birth, a baby obviously not her husband's, women abused by their husbands. Also, the writer was doing her three months "district" midwifery training with nuns and staying at the convent (given the fictional name of The Midwives of St. Raymund Nonnatus), so she describes some of their personalities. A book which is sad in one chapter and funny in the next chapter.

St. Raymund Nonnatus is the Patron Saint of midwives, obstetricians, pregnant women, childbirth and newborn babies. He was delivered by caesarean section ('non-natus'='not born') in Catalonia, Spain, in 1204. His mother, died at his birth. He became a priest and died in 1240 (p. 5).

Some Membership Fees

Association of Radical Midwives (ARM), www.radmid.demon.co.uk £30 annually.
Midwifery Matters (quarterly).

Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN),
www.awhonn.org $149 US (Associate non-nursing $132 US). *JOGNN,* and *AWHONN Lifelines* every two months. *AWHONN Canada Connection* three times a year.

Midwives Information & Resource Service (MIDIRS), www.midirs.org £68 annually.
MIDIRS Midwifery Digest (quarterly).

Royal College of Midwives (RCM), www.rcm.org.uk £99.36 annually for overseas membership without insurance. According to Canadian law there is no reciprocity of insurances.
RCM Midwives Journal (monthly).

Society of Obstetricians and Gynaecologists of Canada (SOGC), www.sogc.org
Associate RN, RM or PhD $100, Allied health care $200, Associate health care $140 annually. *Journal of Obstetrics and Gynaecology of Canada.*

ASSOCIATION OF MIDWIVES OF NEWFOUNDLAND and LABRADOR
APPLICATION FOR MEMBERSHIP
2005

Name: _____
(Print) (Surname) (First Name)

All Qualifications: _____

Full Address: _____

_____

Postal code: _____ Telephone No. _____
(home)

Telephone No. _____ Fax No. _____
(work)

E-mail Address: _____

Work Address: _____

_____

Area where working: _____

Retired: _____ Student: _____ Unemployed: _____

List of Organizations of which you are a member (the Association receives requests from various organizations for representatives to review articles, attend conferences, be on committees). Your name would not be forwarded without your consent.

Provincial: _____

National: _____

International: _____

Would be interested in participating in a research project if asked: Yes ____ No _____

I agree to my address, postal and Internet, to be released to CAM: Yes ____ No _____

If already pay CAM fees as a **Full** member of another Canadian Midwives Association, name of Association:

_____

I wish to be a member of the Midwives Association and I enclose a cheque/money order from the post office

for: $_____
(Cheques/money orders only (no cash) made payable to the Association of Midwives of Newfoundland and Labrador).
Full membership for **ALL** midwives is **$75.00** (as this includes the Canadian Association of Midwives fees which the Association has to pay). $40.00 if pay CAM membership through another Midwives Association.
Associate membership for those who are <u>not</u> midwives is **$40.00**
Membership for those who are unemployed/retired is **$20.00**
Membership for those who are residing <u>outside of Canada</u> **$85.00** (to cover the cost of the extra postage).

Signed: _____ Date: _____

Return to: Pamela Browne, Treasurer, Box 1028, Stn. C, HVGB, Labrador, NL, A0P 1C0